Submission to the Commission on the Future of Health Care in Canada

The Romanow Commission

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EXECUTIVE SUMMARY

Nova Scotia faces serious challenges in delivering optimal health care and preventing illness among its citizens. This submission provides a situational analysis of Nova Scotia's health care environment and some of the innovative approaches the province has undertaken to improve the system. It also outlines some of the ways that the Atlantic provinces have collaborated to enhance health care across the region. The report documents Nova Scotia's recommendations for changes to the *Canada Health Act*, based on its experiences. Six broad themes make up the focus of Nova Scotia's written submission to the Commission on the Future of Health Care in Canada:

1. The Health of Nova Scotia's Population
2. Sustainability
3. Health Human Resources
4. Regional Medical School Costs
5. Research Funding
6. The Canada Health Act

1. The Health of Nova Scotia's Population

Nova Scotia consistently ranks higher on health needs indicators than other provinces and territories. Statistics Canada data shows that Nova Scotia has the highest provincial rate of cancer, high blood pressure, respiratory disease mortality, and self-reported asthma prevalence, and the second highest rate of obesity, lung cancer, diabetes and stress. Cape Breton data are even more dramatic, showing residents have the lowest life expectancy of the 54 major health regions in Canada.

A slow-growth economy and subsequent lack of economic well-being is a major factor in the health of Nova Scotia's population. Nova Scotia has amongst the highest percentage of seniors in the country, likely due to the large out-migration of working-age individuals. The province has a high rural population, one that also tends to be older than in urban areas. Attracting and retaining physicians and nurses to serve these rural areas is an ongoing difficulty. Finally, Nova Scotia has the highest rate of smokers in Canada at 30%, with its resulting impact on chronic disease and costs to the health care system.

Given the large variation in health need indicators between Nova Scotia and other provinces, health service demand is higher. In response, Nova Scotia is moving towards an integrated, community-based health care system with a focus on population health. This has included new directions on:

- Preventive Health and Wellness
- Primary Care Reform
- Community-Based Mental Health
- Aboriginal Health
- Quality in Service Delivery.

In addition, Nova Scotia is collaborating with its Atlantic partners on primary care and population health, including developing an Atlantic Wellness Strategy.

2. Sustainability

Given its high burden of illness, covering the costs of health care presents a significant challenge for Nova Scotia. The accelerated movement to an equal-per-capita Canada Health and Social Transfer (CHST) in 1999 resulted in fewer federal health care dollars as a percentage of the provincial health budget. Fixed health care costs have also increased. Adding to the serious health cost pressures is Nova Scotia's slow-growth economy and high debt load. While the Province is taking measures to control costs, Nova Scotia is less able to invest in improving the performance of the health care system.

Nova Scotia is committed to investing more of its health care dollars in prevention and wellness to reduce the more costly burden of treatment and acute care service delivery. However, predictable and stable federal funding is needed, tied to a national framework for standards. It is time to replace the CHST with a health-only transfer based on actual health needs, not on per capita funding.

To promote sustainability, the Department of Health established District Health Authorities with an enhanced system of financial accountability, released a clinical services report to guide hospital health service planning, and launched a project to improve accountability for government funds provided to agencies and organizations. To remove duplication of effort, Nova Scotia and its Atlantic partners created an Atlantic Common Drug Review Process in January 2002.

The Department has also made important strides in improving information management. Health Infostructure Atlantic (HIA), led by Nova Scotia, is developing a common information management structure to support health care across the Atlantic region. Nova Scotia is also creating a single, integrated hospital information system – the first of its kind in Canada – that will form the cornerstone of a person-centered electronic health record for all Nova Scotians.

3. Health Human Resources

Nova Scotia is committed to the "three R's" of health human resources – recruitment, retention, and retraining. However, inability to compete with wage incentives offered by wealthier provinces and movement of the workforce outside of Nova Scotia have proved challenging in maintaining the right complement of professionals in the province.

To improve system stability, there will need to be more secure financing for health care professionals. Working environments of health care professionals must also be improved to deal with their high rates of burnout, illness, injury and disability, and the impact of these factors on patient outcomes. Care teams working across professional and organizational boundaries, and professionals having the flexibility to make best use of their skills, can create healthy work environments and positive patient outcomes.

Nationally, we need to take consistent approaches to training, skills and licensing, and rural health care needs, rather than the patchwork approach that currently exists. All stakeholders should be at the table.

To improve the situation at a provincial level, the Nova Scotia Department of Health launched the Nova Scotia Nursing Strategy in April 2001 and has developed an extensive incentive program for physician recruitment. A Physician Resource Planning Steering Committee is in place to develop and apply a rigorous methodology for determining the optimum number and geographic distribution of physicians by type of service. In collaboration with its Atlantic partners, Nova Scotia is developing a Health Human Resources Plan that will identify long-term regional needs.

4. Regional Medical School Costs

There are many problems with current funding practices for regional medical schools such as Dalhousie University's Faculty of Medicine. The funding approach is based on a historical model and not on needs, work performed, outcomes or productivity; as such, it does not reflect the unique costs to Nova Scotia for supporting the medical education infrastructure across the Maritime region. Moreover, federal funding practices and levels do not provide a mechanism to deal with population growth, demographic changes or the need to increase research activity at Dalhousie to become nationally competitive, further aggravating the situation.

The Nova Scotia Department of Health is currently involved in Phase I with the Dalhousie Medical School in developing a funding formula that takes into consideration issues of population growth, demographics and research activities. Nova Scotia and its Atlantic partners are also developing health profession education strategies that will meet current and future health workforce needs in the region.

5. Research Funding to Nova Scotia

Nova Scotia researchers require a fairer share of federal funding for front-line research and to build research capacity. As is evident from the recent allocation of grants from the Canadian Foundation for Innovation, the Canadian Institutes for Health Research, and the Social Sciences and Humanities Research Council, Nova Scotia researchers have not received an equitable share of federal research dollars.

There should be a more equitable way of awarding grants that takes into consideration research being done in all geographic areas in the country. The absence of funding that supports research infrastructure continues to place Nova Scotia universities at a disadvantage when competing with larger institutions in Ontario, Quebec and Alberta. Consideration might be given to a new infrastructure program for the smaller medical schools in provinces such as Nova Scotia, Newfoundland and Saskatchewan. Nova Scotia and the federal government might also work as partners with Nova Scotia universities to expand incubator models as engines of research and growth, and allow for investment incentives.

In Fall 2001, the four Atlantic provinces increased their financial commitment to research into health promotion. The additional funding will enable the Atlantic Health Promotion Research Centre to build knowledge, develop capacity and increase grant applications to benefit each province individually and the region as a whole. Provincially, the Nova Scotia Health Research Foundation, which fosters health research, awarded $4.3 million in grants to Nova Scotia researchers in 2000-2001.

6. The Canada Health Act

The Nova Scotia Department of Health believes the five principles of the *Canada Health Act* (CHA) – public administration, comprehensiveness, universality, portability and accessibility – are sound. However, they took effect in 1984 at a time when most non-physician health spending was done in hospitals. Hospital spending now accounts for less than one-half of total health spending. The CHA needs to be modernized to reflect current treatment delivery and adequate reimbursement for the wider spectrum of health services, including long term care, home care and pharmaceuticals.

The Nova Scotia Department of Health recommends that:

- The principle of comprehensiveness reflect the health care delivered in the community. As a minimum, all medically necessary health care services should be covered, regardless of where they are delivered.

- The CHA should be amended to cover "health services" not just "medical services." This would include health promotion/disease prevention, primary care, mental health, rehabilitation, chronic care, as well as home care services, medically necessary portion of long term care and drugs when they are direct substitutes for hospital care.

- The CHA ensure that funding to the provinces and territories reflects actual health service delivery costs.

- There be an element of personal responsibility in the CHA. Canadians in general must take a personal responsibility for lifestyle choices that affect their health, either by prevention of illness or by paying for some of their care.

- Canadians have some insurance/assistance for pharmacare, home care and long-term care. The CHA should include coverage for all of the parts of the health care system, but it should be the same level of coverage across the country.

- If premiums are introduced, exceptions be made for those with low incomes and genetic diseases.

The gap between the potential of the *Canada Health Act* and what needs to take place includes not just changes to the legislation, but to the funding of health care and its mode of governance. Increased federal funding should correspond to an enlarged definition of coverage or comprehensiveness. The Canada Health Act recognizes that a healthy population is a national resource, and the Federal Government must reassume its responsibility to help ensure that all Canadians have an opportunity to be healthy.

1. *The Health of Nova Scotia's Population*

Current Health Status of Nova Scotians

In its report *Federal Funding for Health Care: Are Provinces Getting Their Fair Share*, the Population Health Research Unit at Dalhousie University examined national population health issues as they related to Nova Scotia. Some of its critical findings showed that, in comparison to other provinces and territories across Canada, Nova Scotia has the:

- Highest
  - level of poor self-reported health status
  - prevalence of chronic conditions such as diabetes and activity restrictions
- Second highest
  - premature mortality rates
  - prevalence of heart disease
  - risk of depression
- Third lowest
  - Life-expectancy
  - Age standardized mortality
- Third Highest
  - Self-rated chronic stress levels
  - Percentage of females over the age of 65.

No other province ranked as consistently high as Nova Scotia on all of the need indicators. These findings are well supported by other research. Statistics Canada data shows that Nova Scotia has the highest provincial rate of cancer (all malignant neoplasms), high blood pressure, respiratory disease mortality and self-reported asthma prevalence; the second highest provincial rate of obesity, lung cancer, diabetes and high life stress based on personal situation; and the third highest rate of regular/heavy alcohol use as a percentage of the population.

Even more startling are the health determinants data from the Cape Breton District Health Authority. Residents of Cape Breton, Nova Scotia have the lowest life expectancy – and the lowest disability-free life expectancy – of the 54 major health regions in Canada.

Impacting on health care in Nova Scotia and elsewhere are factors such as the economy, the aging population, rural versus urban residency and a high rate of tobacco use. Historically, Nova Scotia has lagged in overall economic performance relative to many other provinces, and today has higher than average unemployment, lower economic growth and less ability to access source revenues. With economic environment a

significant factor in population health outcomes,[1] the following data indicate that Nova Scotians are at higher risk for poor health.
Compared with other provinces, Nova Scotians have:

- The second-lowest rate of full-time employment, with large regional differences[2]
- An average income at 85% of the Canadian average
- High income inequities for single parent families and seniors, especially females
- The highest incidence of children in lone-parent families
- The highest rate of child poverty, as measured by Market Basket Measure
- High employment uncertainty, as governments rationalize programs and services.[3]

Nova Scotia also has the third highest percentage of seniors in the country. This is likely due to Nova Scotia's large out-migration of working-age individuals, with very little immigration. From a population health perspective, an aging population brings higher levels of acute and chronic illnesses with the attendant demand for services. With a large senior population, encouraging lifestyle changes to improve health can prove more challenging, particularly with many seniors located in rural areas.

Rural and urban differences in health status, health determinants and access to services are also important. Attracting and retaining physicians and nurses to isolated and rural areas is an ongoing difficulty. Possible solutions for expanding rural outreach are through telehealth, full utilization of roles of existing professionals and expanding the role of current providers. Nova Scotia will continue to explore these and other options for service provision.

With the highest rate of smokers in Canada as a percentage of the population (30%), Nova Scotia has the ingredients for exponential increases in chronic disease that leads to a significant economic burden in a society already economically challenged.

Nova Scotia Health: Addressing Health Needs

Given the large variation in health need indicators between Nova Scotia and other provinces, there is a corresponding variation in health service demand. There is obviously a strong relationship between the utilization of health services and the health status/health needs of the population. In response, Nova Scotia is moving towards an integrated, community-based health care system with a focus on population health.

Many interrelated factors and conditions determine health. It is clearly appropriate that Nova Scotia improve the health status of the whole population as well as specific groups. Nova Scotia is seeking to address the broad determinants of health, including:

- Social, economic and physical environments
- Healthy child development
- Personal health practices
- Individual capacity and coping skills

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[1] Strategies for Population Health: Investing in the Health of Canadians, prepared by the Federal, Provincial and Territorial Advisory Committee on Population Health, 1994.
[2] Labour Force Survey, Statistics Canada, 2001
[3] *Nova Scotia A Social Perspective*, Nova Scotia Statistics Agency, December 2000.

- Biology and genetics

Within its challenging health care environment, the Province of Nova Scotia is committed to delivering the best possible health care services to Nova Scotians. The Nova Scotia Department of Health is leading the evolution of health care in Nova Scotia, directing the system towards an integrated and community-based focus. Importantly, Nova Scotia continues to re-align health system incentives to support population health. Examples of this include delivering primary health care in a multidisciplinary environment, alternative funding for physicians instead of fee for service and telehealth opportunities.

The Province is committed to identifying and implementing best practices in health care and making the system work better to meet the needs of our citizens. We have done this by tackling the following issues.

Preventive Health and Wellness

- Nova Scotia has implemented programs promoting healthy eating, physical activity, tobacco control and addiction management. The Tobacco Control Strategy, a multi-faceted approach to smoking cessation based on best practice, was introduced in 2001.
- A physical activity strategy called Physical Activity in Youth is currently being launched in conjunction with the Sport & Recreation Commission.
- A Blood Borne Pathogens Strategy is under development.
- *Taking Steps to Prevent Falling in Nova Scotia*, a discussion paper, was produced to educate seniors and their family members on how to prevent falls. Falling is a serious health problem that occurs in one in three seniors. It accounts for most injuries to the elderly, with annual treatment costs estimated at $16 million per year in Nova Scotia.
- A comprehensive influenza strategy

Primary Care Reform

- Nurse practitioners are working in four Primary Care Demonstration sites as part of the *Strengthening Primary Care in Nova Scotia Communities* initiative. Their expanded role in primary care delivery has been legislated and each site has developed collaborative practice agreements between nurse practitioners and physicians. Provision for expansion of these services is included in this year's budget.
- The North Queens Community Clinic opened in Caledonia on January 13, 2002.
- The Long & Brier Island site now allows paramedics to give flu shots, in order to make the best use of resources in a low population area.

Community-Based Mental Health

- *Mental Health: A Time For Action* was produced with broad input from care provider organizations, consumer groups and non-governmental organizations across the province. The Nova Scotia Department of Health is implementing the report's recommendations for community-based mental health services, with an increased focus on services for children and youth.

Aboriginal Health

- The Nova Scotia Department Of Health is collaborating on the Eskasoni Primary Health Care Project.
- The Department of Health co-chairs the Health Working Committee of the Tri-Partite Forum. The committee has completed an inventory and developed an assessment plan of health services offered for registered and non-registered natives living on and off reserve. The committee's priorities are:

    1. decreasing the barriers to health care services
    2. improving communicable disease control
    3. improving addictions services
    4. implementing the Canadian diabetes strategy
    5. improving mental health services

Quality in Service Delivery

- To improve seniors' access to continuing care services, the Nova Scotia Department of Health launched Single Entry Access to home care, long-term care, small options homes, community residences and residential care facilities. Seniors and their family members now have one-stop access to these services in their communities by calling a single 1-800 number.
- To improve access to diagnostic services, the province is embarking on a provincial waitlist strategy for CT and MRI.

Nova Scotia and its Atlantic Partners

Atlantic Canada Primary Care Collaboration

- The Atlantic Partners have identified the following areas for collaboration in primary care: basic interdisciplinary education for providers, re-orientation of current providers to a renewed primary care system, tele-triage and access to self-care information.
- The Atlantic Health Strategic Planning Group, established by the four Atlantic Region Deputy Ministers of Health and the Atlantic Regional Director General of Health Canada, is focused on developing an Atlantic Wellness Strategy.

Other Atlantic Initiatives

- The Atlantic Common Drug Review Process, discussed later.
- Health Infostructure Atlantic
- Joint HHR Planning

2. *Sustainability*

The Cost of Health Care in Nova Scotia

Health care funding to Nova Scotia must take into consideration the higher health care needs of the province's population. The accelerated movement to an equal-per-capita Canada Health and Social Transfer (CHST) in 1999 did not address the impact of Nova Scotia's slow growth and less healthy population. Given its high burden of illness, the costs of health care present a more significant challenge for Nova Scotia than many other jurisdictions.

Nova Scotia is working hard to manage its health care system in the face of fewer federal health care dollars. The Department of Health is taking measures to control costs while the Province is dealing with a staggering debt load. Nova Scotia currently has the highest debt-to-GDP-ratio of any province at 48%. The national average debt-to-GDP-ratio is about 25%. Nova Scotia also has the highest per-capita debt in Canada, currently at $12,380.00 per person. Higher debt payments and higher demand for health care services, Nova Scotia is less able to invest in monitoring and improving the performance of the health care system.

Fixed health care costs are increasing, adding to the serious health cost pressures faced by the province. For example, Nova Scotia is looking at minimum annual cost pressures of at least 5% just to maintain health care that include:

2.5 % for pharmaceuticals
1.5 % for inflation on medical/surgical supplies
1.0 % for increase in costs for utilization.

When wages are added, the cost pressures approach 12-14%. In addition, non-hospital program costs continue to increase. For example, in 1995-1996 it cost about $2,700 per month to care for a resident in a nursing home. By October 2001, the costs had increased to $4,000 per month. With the growing senior population, these numbers will continue to increase. As an equalization-receiving province, Nova Scotia cannot continue to build debt in order to fund its health care costs.

Type of Service	**Year 1994 - 1995**	**Year 2001 – 2002**
Home Care	$ 21.0 million	$ 108.0 million
Long-Term Care	$ 60.0 million	$ 181.0 million
Hospitals	$ 638.0 million	$ 925.0 million

Nova Scotia will continue to redirect more of its health care dollars towards "upstream" prevention and wellness initiatives to try to reduce the more costly burden on "downstream" treatment and acute care service delivery in future years.

However, predictable and stable federal funding is needed, tied to a national framework for standards. Funding for health care is a major issue in Nova Scotia. It is time to replace the CHST with a health-only transfer based on actual health needs, not on per capita funding.

Nova Scotia supports the principles of the *Canada Health Act*, but flexibility must be introduced to expand "comprehensiveness" and re-define "medical necessity" to include home care, long-term care, pharmacare, health promotion and disease prevention.

Nova Scotia Health: Sustainability Initiatives

- In 2001, the Department of Health released its clinical services report, *Making Better Health Care Decisions for Nova Scotia*. Using the criteria of sustainability, quality, access and affordability, the report classifies the province's hospitals into district, tertiary and community, taking into account service demands of the population served and the complexity of care provided. The report addresses issues of rural/urban sustainability. Two more reports are in progress: Phase II on Continuing Care and Phase III on Primary and Emergency Care.

- Nine District Health Authorities (DHAs) replaced the regional health board structure to give communities a stronger voice in local health care. Legislation also formalized the planning and advisory role of 37 Community Health Boards to the DHAs. The DHAs are required to make regular financial and operational reports and submit audited financial statements to their boards and the Minister of Health every year. In February 2002, a plan to develop a funding methodology for DHAs was announced, which will take into consideration the burden of illness in the population that the districts serve.

- The Department of Health launched a project to improve accountability for government funds provided to agencies and organizations. In conjunction with other departments, standardized criteria were developed for grant eligibility and reporting outcomes.

Information Management

- Health Infostructure Atlantic (HIA), led by Nova Scotia, is developing a common information management structure to support health care across the Atlantic region. With funding from Health Canada, HIA is implementing components of a common electronic health record, including a common client registry, information systems to support case management of home care clients, and teleradiology (digital storage and transmission of x-rays across Atlantic Canada). We are now in the process of considering priorities for future collaboration, for example, a pharmacy information system.

- Nova Scotia is creating a single, integrated hospital information system that will form the cornerstone of a person-centered electronic health record for all Nova Scotians. The design phase of this project, which is the first of its kind in Canada,

is nearing completion, with system introduction planned from Fall 2002 to Winter 2003-2004.

Nova Scotia and its Atlantic Partners

Pharmaceuticals

- The Atlantic provinces created an Atlantic Common Drug Review Process in January 2002. The Committee removes duplication of effort. An single Expert Advisory Committee reviews new drugs and makes recommendations about whether a drug should be listed. If the committee recommends that a drug not be listed, none of the Atlantic partners will list it. If the committee recommends that a drug be listed, each province can then make the final decision about whether it will be added to its formulary.

3. *Health Human Resources*

Nova Scotia is committed to the "three R's" of health human resources – recruitment, retention, and retraining. However, there are several challenges faced by Nova Scotia in maintaining the right complement of professionals across the province.

There are wage disparities across the country, and smaller and less wealthy jurisdictions like Nova Scotia are finding it increasingly difficult to keep up with the wage incentives offered in wealthier provinces. This is a large contributor to the situation we have with half of Nova Scotia-trained health professionals moving elsewhere. A national approach to health human resources is urgently needed. The focus needs to be broadened beyond just physicians and nurses. Provinces and territories should not have to rigorously compete with each other for health care providers.

Clearly, stability needs to be put into the system. Consistent funding levels would provide security to people working in or entering the system. It would also assist in repatriating workers back to their professions. The working environments of health care professionals must also be improved to deal with increasing rates of burnout, illness, injury and disability, and the impact of these factors on patient outcomes.

The care teams of today and tomorrow must focus their activities across physician, nursing, and other allied health professional associations and organizations, rather than working independently within their own profession. Giving all professionals the flexibility to make best use of their skills and knowledge provides benefits in terms of healthy work environments and positive patient outcomes. Issues of autonomous practice also need to be considered. Autonomous practice allows professionals to have control over their work, i.e. having control over scheduling and playing both an independent and dependent role, with each contribution recognized in a systems approach.

All stakeholders, including unions, professional associations, government, educational facilities and employers, need to be at the table to work out solutions for health human resource issues. Nationally, we need to take consistent approaches to training, skills and licensing, rather than the patchwork approach that currently exists. The Department of Health also recommends a national approach be developed to address rural health care needs, given the large rural and remote populations across the country.

Nova Scotia Health Human Resources Initiatives

- The Nova Scotia Nursing Strategy launched a range of recruitment and retention efforts in April 2001. Elements of the strategy are being implemented by DHAs, Provincial Health Centres and Nursing Schools throughout the province with good success to date.

- Nova Scotia offers extensive incentives such as signing bonuses, guaranteed minimum billing, moving allowances and debt assistance through its physician recruitment program.

- To address the distribution of physicians across the province, the Department of Health has implemented locum services, continuing education, new stable funding plans and support programs for rural MDs. The province is examining other solutions such as retraining, increasing seats in the medical school and working with the medical school to encourage rural practice.

- A Physician Resource Planning Steering Committee is in place to develop and apply a rigorous methodology for determining the optimum number and geographic distribution of physicians by type of service. The Plan will support the Clinical Services Plan completed in 2001.

- In 2000-2001, 1,200 professionals participated in courses offered by the Atlantic Health Training Simulation Centre, which operates in partnership with the QEII. The Centre's Human Patient Simulator helps physicians, paramedics and nurses develop hands-on critical thinking skills.

Nova Scotia and its Atlantic Partners

- Nova Scotia obtained an HRDC grant to develop a human resources plan that better aligns health care system needs with the output of health education programs. Similar activities are underway in the other Atlantic provinces.

- To facilitate regional planning, the Atlantic partners are developing a regional health human resource information database including an inventory of the supply, demand and training opportunities for health professionals based on the work described above.

- The next step, An Atlantic Canada Health Human Resources Plan, that will identify long-term regional needs is being actively pursued.

4. *Regional Medical School Costs*

New funding arrangements that reflect the unique costs to Nova Scotia for supporting medical education across the Maritime region are needed. The current funding approach is based on a historical model rather than on needs, the work performed, outcomes or productivity.

The current funding is neither stable nor equitably apportioned across the Maritime provinces. According to Dalhousie's report to Nova Scotia's Ministers of Health and Education in January 1997, the governments of New Brunswick and Prince Edward Island provided 29% of the medical students and 12% of the residents to the school, but contributed only 13% of the education costs of their students. The report recommended through the Maritime Provinces Higher Education Commission, that the contribution of the other two Maritime provinces be increased to a level closer to the actual cost.

At present, federal funding practices and levels do not lend support to the medical schools in the region. The current funding models do not provide a mechanism to deal with population growth or demographic changes and economic inequity, nor do they address the need to increase research activity at the Dalhousie Faculty of Medicine to become nationally competitive. In 2002, Dalhousie and Memorial Universities have the only medical schools in Canada unable to afford the costs of increasing medical school seats. A new academic funding model will need to take growth factors into account.

Nova Scotia Initiatives on Medical School Costs

The Nova Scotia Department of Health is currently involved in Phase I with the Dalhousie Medical School in developing a funding formula that takes into consideration issues of population growth, demographics and research activities.

Nova Scotia and its Atlantic Partners

The Nova Scotia Deputy Minister of Health, in conjunction with the Nova Scotia Deputy Minister of Education, is collaborating with the Deputy Ministers of the other Atlantic provinces to develop health profession education strategies that will meet current and future health workforce needs in the region.

5. *Research Funding to Nova Scotia*

Nova Scotia researchers require a fairer share of federal funding for front-line research and to build research capacity. For a long time, Nova Scotia researchers have not received an equitable share of federal research dollars.

- **Canadian Foundation for Innovation (CFI)**: In the latest round of projects approved by the CFI (up to January 30, 2002), Nova Scotia received only 1.3% of total projects approved. The other three Atlantic provinces received less than 1% each. By contrast, Ontario received 30% and Quebec received 24% of the total. Only 137 of the 1,901 provincial projects funded by CFI were in Atlantic Canada. The total amount for the region is less than Nova Scotia's population share.

- **Canadian Institutes for Health Research (CIHR)**: The CIHR awarded over $35 million in research funding to University of Toronto (UofT) in 2001, the highest individual amount awarded to one institution. UofT and its affiliates also received the highest number of research grants (88). McGill University received over $27 million to fund 71 research grants. University of Toronto and McGill University's awards individually were more than Atlantic Canada, Manitoba and Saskatchewan's combined. Nova Scotia received the smallest dollar amount of any province, with $1.6 million awarded to Dalhousie University to fund six of its 30 research grant applications. The second lowest dollar amount, $1.7 million, was awarded to Newfoundland's Memorial University for four grants from 14 applications.

- **Social Sciences and Humanities Research Council (SSHRC)**: In 2000, Nova Scotia received only 2.5% of the $401 million spent on research, compared with 31% for Quebec and 39% for Ontario. Remarkably, more federal funding flows out of the country from SSHRC than into Atlantic Canada.

When research dollars are given to institutions, they are like transfer payments and wealthier provinces are receiving a disproportionate share. In a report to Nova Scotia's Health and Education Ministers in 1997, Dalhousie University stated that, "In comparison to other Canadian Medical Schools, the research dollars available to Dalhousie fall far below the national average or even the per capita amount one would expect for Medical School registration numbers or the Canadian population living in the Maritime provinces."

There should be a more equitable way of awarding grants that takes into consideration research being done in all geographic areas in the country. Awards on a per capita basis are not necessarily the answer, since they would not account for the need to build research capacity. The absence of funding that supports research infrastructure continues to place Nova Scotia universities at a disadvantage when competing with larger institutions in Ontario, Quebec and Alberta. Consideration should be given to federal funding for a new infrastructure program for the smaller medical schools in provinces such as Nova Scotia, Newfoundland and Saskatchewan.

Nova Scotia and the federal government need to work as partners with Nova Scotia universities to expand incubator models as engines of research and growth, and allow for investment incentives. Some of the current university-led health/business incubators are: NovaNeuron, Fusogenix, OncoDynamics and Delex Therapeutics.

What Nova Scotia is Doing on Research

In December 1998, Nova Scotia created the Nova Scotia Health Research Foundation (NSHRF) to foster health research throughout the province. The Foundation assists and collaborates with individuals and organizations conducting research in four key areas: health policy, health services, health outcomes and medical. One of the primary roles of the NSHRF is administering grant programs to help researchers financially. The NSHRF works with public and private sector partners to raise awareness of health research issues in Nova Scotia and support the development of a vibrant, broad-based health research community. In 2000-2001, the NSHRF awarded $4.3 million in grants to Nova Scotia researchers.

Nova Scotia and its Atlantic Partners

- **Atlantic Health Promotion Research Centre:** In the Fall of 2001, the four Atlantic provinces increased their financial commitment to health promotion research. The additional funding will enable the centre to enhance knowledge building, capacity development and should increase the number of grant applications that could benefit an individual province and the region as a whole.

6. The *Canada Health Act*

The *Canada Health Act* contains five principles:

1. Public administration
2. Comprehensiveness
3. Universality
4. Portability
5. Accessibility.

The Nova Scotia Department of Health has considered the principles and believes they are sound. However, they were written for a different time and need to be modernized to reflect current treatment delivery and adequate reimbursement for health services.

The *Canada Health Act* (CHA) took effect in 1984 at a time when most non-physician health spending was done in hospitals. Hospital spending now accounts for less than one-half of total health spending. The CHA currently co-pays provinces and territories for medically necessary services delivered only by hospitals and physicians. It does not cover the whole other range of medically necessary services such as home care, pharmacare, dental care, long-term care and optometry services which have gradually been included in most provinces.

In the words of Monique Begin, architect of the CHA, at a health policy conference in February 2002, "...a legislation based solely on hospitals and doctors, as is the CHA, is not appropriate at all, and is even detrimental to good health policy."

The Nova Scotia Department of Health specifically recommends that:

- The principle of comprehensiveness must reflect health care delivered in the community. All medically necessary health care services should be covered, regardless of where they are delivered.

- The CHA should be amended cover to "health services" not just "medical services." This would include health promotion/disease prevention, primary care, mental health, rehabilitation, chronic care, home care services, medically necessary portion of long-term care and drugs when they are direct substitutes for hospital care.

- The CHA should ensure that funding to the provinces and territories reflects actual health service delivery costs. When provinces pay for necessary health services not covered by the CHA, it widens the gap between the "have" and "have-not" provinces. Less wealthy provinces are required to deliver CHA services at the same national standards as wealthier provinces, and in addition must cover an ever-growing basket of services from provincial funds. This causes the debt burden to grow in already cash-strapped provinces such as Nova Scotia.

- There should be an element of personal responsibility in the CHA. All provinces and territories are promoting wellness and prevention programs. Canadians in general, must take a personal responsibility for lifestyle choices that affect their health, either by prevention of illness or by paying for some of their care.

- Canadians should have some insurance/assistance for pharmacare, home care and long-term care. The CHA should include coverage for all of the parts of the health care system, with the same level of coverage across the country.

- If premiums are introduced, exceptions should be made for those with low incomes and genetic diseases.

To conclude, the gap between the potential of the *Canada Health Act* and what needs to take place includes not just changes to the legislation, but to the funding of health care and its mode of governance. Increased federal funding should correspond to an enlarged definition of coverage or comprehensiveness.

Appendix 1:

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